PRACTICE OBSERVED

Sex Problems in Practice

Sex and physical disability

WENDY GREENGROSS

Few general practitioners are asked to cope with disabled people's sex problems, and it is pertinent to ask in this International Year of Disabled People whether this is because disabled people don't have sex problems, or whether, for some reason, disabled people have more difficulties than others in putting their needs and their problems into words that the general practitioner can accept and understand.

Mary, married to Frank who has severe cerebral palsy, consulted her GP as to whether it would be safe for her to use the pill. "Surely, you don't have intercourse with him," was the response, and Mary, embarrassed and upset, retreated to manage as best she could.

Arthur, with multiple sclerosis, had been fitted with an indwelling catheter. "Should I take it out for sex?" he asked his GP. "Best not to bother with sex," he'd been told, "You'll probably find it too tiring, all the same."

Jean, aged 36, living with a married man, had a colostomy for ulcerative colitis. Because she was unmarried no one had mentioned sexual intercourse, and Jean was too shy to ask whether it was safe or permissible.

Peter, aged 13, with muscular dystrophy, masturbated frequently. His parents were extremely anxious as to whether it would alter the progress of his disease, but could not express their anxiety to their "nice lady doctor."

General practitioners are gradually beginning to accept that good sex is as beneficial as good medicine, and some are prepared to listen to their patients' sex problems and offer advice or referral. Unfortunately this new broad-mindedness does not seem to include the disabled, and doctors tend to regard all handicapped people as incapable of having sexual feelings or sexual needs.

General practitioners probably reflect the attitudes of a society bombarded with sex, having been given the impression that everybody else is having a stupendously exciting and rewarding sex life; never failing, never being too tired, and able to have multiple orgasms at the drop of a hat; but knowing that their own sex life doesn't measure up to their expectations or their hopes. The thought that even "cripples" might perform more satisfactorily, more frequently, or more enjoyably than they do themselves may be too threatening to contemplate, and they would rather regard them as sexless than as rivals.

Most overt sexual displays, in books and films and plays, tend to dwell on the young and the beautiful; and the thought of twisted, maimed, unattractive bodies enjoying sexual activities may awaken "gut" feelings of revulsion or distaste that many general practitioners are unable to cope with. There is also a very real anxiety that they may be asked questions that they cannot answer and that, having once opened the floodgates, they may be faced with problems that have no solutions and for which there are no available resources.

Many patients are worried about resuming sexual activity after operations or cardiovascular episodes and are afraid of asking for advice. They may have difficulty in accepting the personal mutilation of mastectomy or amputation or colostomy, or the changes associated with skin disease or stroke, which alter their perceptions of their own body image and make them feel damaged and unlovable, so that they cannot believe that they can still be attractive to a sexual partner.

Strong interpersonal feelings, such as anger, resentment, depression, and helplessness that cannot be expressed, sometimes obtrude and interfere with sexual arousal. Many patients feel angry and resentful at having to suffer from chronic debilitating disease that enforces dependency and prevents ordinary activity, and they may find it particularly difficult to express these feelings to a spouse who is already making great personal sacrifice to care for the disabled partner. Loss of libido is an early symptom of depression, and many disabled patients are deeply depressed. This is often untreated because the doctor either fails to recognise the depression or assumes that it is inevitable and a normal part of the disease process.

London W1

WENDY GREENGROSS, MB, BOBSTROMG, chairman, Sexual and Personal Relationships of the Disabled

Doctors are not very good at communicating information about chronic disease, for medical training is mainly concerned with making people better, and the chronic, deteriorating patient tends to make the doctor feel a failure. As a result these patients receive little information about their disease or about its progress. Many feel that nothing is being done for them and helpless that they can do nothing for themselves, and these feelings of helplessness and impotence find expression in their sexual relationship. Textbooks give doctors little help. Few discuss the sexual implications of disease, and none mention the effect of drugs on libido.

Many consultants choose to ignore the effect of disease processes on sexual performance, and medical and ancillary staff working in hospital departments are often guilty of taking histories of all functions except that of sex, giving patients at an early stage the impression that they can ask questions about any subject, except sex. . . . The implied message is clear—"Once you are disabled, you should not be sexually active."

An eminent physician treating many paraplegic patients said that although men had sexual difficulties after spinal cord injuries, women suffered no sexual disability. A genitourinary surgeon, performing numerous partial amputations of the penis for carcinoma, said that it was no part of his task to talk to his patients about their sexuality. This unwillingness to accept sexuality as a normal and natural part of the disabled and the ill is perpetuated in general practice and often causes great and unnecessary suffering. It is tempting for general practitioners to make value judgments and assume that the disabled neither want nor need sexual pleasure or gratification, but those general practitioners who are willing to listen to disabled people find that they can give help.

Gerald, aged 35, was unemployed because of painful, chronic rheumatoid arthritis that affected all his joints, including his knees, his wrists, and his fingers. He had stopped sexual intercourse with his wife because weight-bearing was impossible. He was deeply depressed at his inability to be either a breadwinner or to satisfy his wife sexually. His practitioner advised him to take his analgesics before sexual activity started, and recommended that Gerald's wife adopt the superior position for intercourse.

John, aged 29 years, with severe cerebral palsy, was in residential care and had recently parted from his girlfriend. He was causing distress to the staff because of his frequent requests for help with masturbation. The matron threatened to have him transferred unless his practitioner would prescribe tablets to lower his libido. The practitioner talked to John, who could not use his hands effectively, and recommended a long-handled vibrator, which John was able to use independently and without help.

Harriet and James had been married for two years when James fractured his spine in a motorcycle accident and became paraplegic. As Harriet had been a nurse before marriage she was able to look after James when he left hospital, but within six months was complaining to her doctor about her inability to respond to James's lovemaking. When Harriet was given an opportunity to talk about her problem it became evident that she was emotionally confused about her dual role of wife and nurse. Her professional training had stressed the boundaries that must be maintained between nurse and patient, and the complete dependency of her husband had forced her to regard him primarily as a patient. Given an opportunity to understand her feelings, she was able to establish new and more appropriate boundaries.

Elizabeth, aged 50, was worried and upset by bilateral osteoarthritis of the hip. She was not complaining of pain, but eventually broke down and told her GP that gross limitation of abduction and external rotation made sexual intercourse almost impossible and she was concerned for the future of her marriage. Both hip joints were replaced, and she was assured that they would not be damaged by renewing sexual activity.

Agnes, aged 36 years, with severe generalised arthritis, haunted the surgery with complaints of pain, until her GP arranged for her to be visited by the domiciliary contraceptive advisory service.

Martin, aged 26 years, with very early multiple sclerosis, complained of impotence dating from his discharge from hospital, until his GP reassured him and told him that his disease was unlikely to be inherited by his 3-year-old son.

The largest number of couples in England tend to use only one position for intercourse, and many can be helped by being given permission to try a different position or use cunnilingus or fellatio. Taking analgesics before sexual activity starts and the use of cushions, pillows, or supports for tender limbs may prevent pain. If intercourse is impossible, pornography, vibrators, dildoes, and other sex aids may afford simple relief for the single person as well as for those with partners. Because limited mobility may put sex shops out of reach and because many disabled people are unable to get to contraceptive clinics by themselves, many can be helped if a confidential escort is provided.

Some sexual difficulties seem to be caused by apparently insurmountable problems, such as the lack of or the loss of a sexual partner, or by diminishing sexual potency or interest, but allowing patients the time and space to talk about *their* anxieties and *their* fantasies is usually helpful and effective.

Relevant disabled organisations can provide written material and booklets, and these are also available from SPOD (Sex and Personal Relationships of the Disabled), who can provide information sheets, details of sex aids, prostheses, and lists of dating agencies. The more difficult problems may need specialist help and these should be referred for counselling or for psychosexual therapy.

ONE HUNDRED YEARS AGO The Royal College of Surgeons of Edinburgh has refused to follow the example of the Physicians, having thrown out, at its last quarterly meeting, a resolution "that the time had come when a change in the manner of admission to the Fellowship was desirable." Had Dr Andrew Wood survived a few weeks longer, it is more than probable that the result would have been different; for, strong Conservative as he was in college as well as in general politics, he held that reform was necessary, and had actually framed a report, which had been adopted by a special committee of that College, the basis of which was examination of candidates. No one knew better than he that, in whatever other directions future legislation bearing on medical matters might take effect, it would most certainly render all honorary titles unregistrable. And thus the Edinburgh College has lost the opportunity of doing gracefully *ex proprio motu*, what it will be sooner or later compelled to do by Act of Parliament. The sale of titles is an anachronism. The manufacture of Fellows at £25 per head is a vicious proceeding, which, directly and indirectly, affects the value of all Scotch qualifications. The general public cannot be expected to discriminate very nicely between honorary titles and qualifications to practise; and it therefore cannot be wondered at that it should, in its ignorance, extend a feeling of suspicion to all the institutions of a country, one of whose principal medical corporations disposes of its honours for so much money. Should a Royal Commission be appointed, many of the hard facts which were stated during the discussion will appear in black and white; and no amount of special pleading will be able to wipe away the obloquy which must and will appertain. The arguments adduced in favour of maintaining the present state of things look almost entirely the commercial line: the College could not afford to throw away a great source of revenue, and so on; but we are thankful to know that there is a strong and rapidly increasing party which deprecates this trademanlike view of the question, and is strongly adverse to the continuance of such short-sighted policy. The motion was lost by only two votes; and we may therefore hope that, when the subject is again mooted, as it will assuredly be next year, the party of progress will be able to assert itself, and remove a stain which sullies the reputation of a corporation which has done, and is doing, good work. (*British Medical Journal*, 1881.)

Practice Reflections

Culling quietly

H G NICOL

We are playing a new game in our surgery. It is called summary cards. Every day each partner is allotted a bundle of medical records that have to be tagged, summarised, and culled. When the summary has been neatly written onto the FP9—pink for a boy, blue for a girl (a curious case of colour blindness at the Ministry?)—each listed diagnosis will receive a number, based on the Royal College of General Practitioners classification of chronic disease. Thus a man aged 52 who had had a serious head injury becomes 2914810, and a girl of 9 with pyelitis 7222710. The first two digits refer to the year of birth—1929. In the third digit 1 is for male, 2 for female. 4810 is the serial number of the disease: thus 2914810. "O brave new world that has such people in't."

Culling is the new word for a process that has to be continuous in general practice if our records are to remain useful and our offices habitable and not swamped in paper. I must confess that I actually enjoy tearing things up and can think of no better mark to a well spent day than a waste paper basket full of carefully shredded letters. Careful shredding is very important for patient confidentiality, and I can foresee a time when an incinerator will be attached to every large group practice.

Many of the letters give me no twinge of conscience as they go. Those written before 1950 are often rather charming—sometimes the typing is illegible and blotched; they bespeak an age when what was said was more important than how it was set down. If the general practitioner was barely known to the consultant he would begin, "Dear Dr Bloggs"; if they were on friendly terms it would be "Dear Rupert." "Dear Bloggs" was an intermediate form of address much favoured by older doctors. "Dear Blogge" carried a promise, it was a step on the ladder. I regret its modern replacement by the term "Dear Rupert Blogge." Where did this interloper come from? Is it even English?

So many of those fat envelopes can in a second be shimmed down. So much that is boring, repetitive, or, with the passage of time, irrelevant can go. Of two or three letters that describe a hernia repair, only one needs to be kept. If a hysterectomy has been done all reference to previous D and Cs and pregnancies can disappear. One of our local consultants writes on heavy water-marked paper, as thick and crinkly as a £10 note. Many of the letters are linguistic gems, but they fit badly into the record envelope and with a tear some must go.

A lesson

Culling is an activity for the quiet hours at the end of surgery. Nothing is so disconcerting for patients as actually to see their medical records disappearing. It has occasionally got to be done when the pressure is on, but I do not recommend it. My destructive passions once very nearly landed me in trouble. Not only did I consign part of a voluminous folder to the waste paper basket in the patient's presence, but I also did it in her house. It was an unforgivable error and I was justly punished for it. As soon as I had left she laboriously emptied the pieces onto the floor, stuck them all together with sellotape, and there before her very eyes were the considered opinions of all the learned doctors on her case. Unfortunately many of the letters contained thumbnail character sketches of herself, which, though pertinent and precise, were largely uncomplimentary and some even libellous. "Dear Doctor," they would begin, "This exceptionally difficult and argumentative lady . . ." and so on. An official complaint was levelled against me on the grounds that I had unlawfully destroyed medical information. The case was quashed immediately as the nonsense that it was, the patient removed from the practice list, and the affair—as these things do—simmered down. I felt sorry for her because in a trice she had seen how the world truly saw her and that is good for nobody, and for myself because I had been so stupid. It was a good lesson.

Culling quietly in the evening after a busy day can be both enjoyable and contemplative. What a revolution is there in the records of only 20 years in general practice for anyone to see. Barbiturates were used broadcast in the 'sixties and 'seventies as sedatives, tranquillisers, and antipruritics. They found their way into all sorts of tonics and placebos. Nowadays, except as antiepileptics, they have disappeared. This was a major advance, though not all of us had the vision to see it as such at the time. During this period the contraceptive pill appeared and later the coil. I can remember being profoundly impressed by a senior partner who dared to use the first antidepressant, Tofranil, on a patient in 1959. In the early 1960s we were still giving the diuretic Mersalyl by injection and had very little else. The whole range of oral diuretics, now of baffling complexity, have come into use in general practice in the past 15 years. I don't think anybody can doubt that doctors are now prescribing more sensibly than they were. They are at least aware of the problem of drug compliance and realise how important it is to keep regimens simple and explain it all to the patient three times. There has been improvement everywhere—except in obstetrics.

Babies

Fifteen or 20 years ago a GP who wanted to could also call himself an obstetrician. In our practice we would do a forceps delivery under general and local anaesthesia, breech and twin deliveries, and manual removal of a placenta—and became quite good at it. We had a well-equipped maternity unit where the staff were accustomed to surgical procedures of this kind. On one memorable occasion I found myself delivering a second twin by internal podalic version and a speech to the local Caledonian Society on the same night. A quick rearrangement of the order of the speeches was all that was necessary, and for the first and only time the "Toon of our Adoption" took precedence over "The Immortal Memory." I am sure Robert Burns would have approved.

Stratford upon Avon, Warwickshire

H G NICOL, BSM, MRCGP, general practitioner

The past 10 years has seen a quiet revolution for the GP obstetrician, and if present trends continue he will soon be one in name only. Strange to say, hardly a shot has been fired either in protest or to celebrate his impending demise. There has been a steady fall in total GP obstetric care. Twenty years ago we looked after about 80% of our maternity cases completely.[1] Figures taken from the practice registers, which go back to 1963, show this clearly:

GP maternity unit confinements	%	Home confinements	%	Hospital confinements
1963	67	13		20
1967	70	20		22
1969	67	14		19
1973	94	2		14

In the past eight years in our practice, there has been a very rapid fall in home confinements to 0·5% in 1976 and hardly any since that time.

Figures obtained from the family practitioner committee show that in 1980 we gave complete maternity medical care to only 4% of our cases. The area health authority paint an even more gloomy picture for general practice. In south Warwickshire as a whole in 1980 there were 6336 births and in only 794 (12%) did the family doctor play a full part.

Despite our virtual abolition of home confinement, in Holland, where homes and people cannot be all that different, home confinement is still very popular and the neonatal death rate among the lowest in Europe second only to Sweden.[2] This week I was culling the records of a pleasant young woman now aged 34. In 1967 and 1969 she gave birth to her two children. Both were perfectly normal confinements, and both took place at home. Only 10 years ago a home confinement was commonplace. Recently two mothers have implored me to allow them to have their babies at home. I replied that I would be delighted but must ask my partners what they think. The onset of labour cannot be planned, and I am not on duty every day. The practice as a whole must decide. I know what the answer will be because it is always the same. The three oldest partners who have experienced home confinements and have the necessary equipment say yes. The three youngest partners say no quite categorically, and they will not be shifted.

Last year a young mother (who was also a doctor) somehow ignored all our protestations and contrived to go into labour quietly at home. She was not going to have her baby in hospital attached to wires and drips and things. At 11 am one morning the midwife called to say that Dr X was fully dilated and would the doctor come? There was amazement, consternation, and near panic in the surgery. One partner discovered an urgent appointment. Another had no midder bag. I was diverted from a geriatric visit by an emergency call over the car radio and got to the house in time to find a happy mother, a happy baby, and a midwife making a cup of tea. There was absolutely nothing to do except to offer congratulations all round.

Giving the patient what she wants

General practice is a service industry. The plumber, the milkman, the postman, the electrician, and the man who mends our ECG machine at £20 an hour also offer a service. The better and the more comprehensive the service, the better the rewards in terms of finance and job satisfaction. I do not mind in the least being compared to a plumber and only hope that my night visit is as essential and useful as his when my hot water cylinder is caving in and about to burst, owing to a frost-induced vacuum in the feeder pipe. Should we simply say: "Home confinement is out, I am not prepared to do it," and thus ignore the expressed request of some of our patients, the continuing success of home confinement in at least one other country, and a growing movement in its favour that is being expressed by women who, rightly or wrongly, appear to detest hospitals? Are they all cranks?

It will always be easier for me to advise confinement in a hospital or general practitioner maternity unit for every patient. All the necessary equipment is there. I won't have to work half so hard, but am I being fair to the small percentage of mothers who really want a home confinement, who have thought it all over, and who appreciate the extra risk? Their homes would have to be carefully vetted to see if they are good enough. Adequate lighting, a flow-mounted anglepoise 2), intravenous dextrose saline and fluid, autoclaved suture equipment, portable lithotomy poles, and infant laryngoscopes and tubes should all be available. Who would be responsible for this? And should the doctor be paid more for the extra work and responsibility that would be entailed? With these provisos is it possible to envisage that home confinement may make a come-back in this country one day for carefully selected cases?

An analogy to the problem of home confinement already exists in general practice. It is accepted by most doctors that the risks of inserting a coil into a nulliparous patient in terms of increased incidence of pelvic sepsis, subsequent sterility, and uterine perforation are too high for this procedure to be routinely recommended. Yet coils are frequently inserted into such patients. They have been told of the extra risk and have accepted it because a coil is what they want and nothing else will do. It follows that the doctors concerned have tacitly accepted that they are providing a service dictated by the patient, a service that they may not even approve of.

There is more to this argument than mere doctoring. It concerns the quality of life that may be more important to some people than life itself. It concerns our Hippocratic Oath to do always that which is best for the patient. Who decides what is best for the patient? Does she decide, or do I? And who is right?

My thanks are due to Mr Eric Evans and his staff of the Family Practitioner Committee, Warwick, and to Mrs Anne Day of the Area Health Authority, Leamington Spa, who have done research for me.

References

1 Country practice revealed. Labour problems. *Update* 1981;**23**:333.
2 Savage A. Personal view. *Br Med J* 1981;**283**:227.

ONE HUNDRED YEARS AGO SIR,—Misfortune seems sadly to have attended Dr Reid's administration of alcohol. The unhappy condition and worse felt by Dr Reid when he thinks of the use, or rather the abuse, he has made of alcohol, is not to be wondered at. He tells us that he used alcohol right and left ten years ago, when his eyes were scaly; that he advised a lady patient to take a glass of gin-toddy every night for a pain in the back; probably Dr Reid's right and left hand use of alcohol also tell upon pain in the hip, pain in the shoulder, pain in the ear, and pain elsewhere. Now, to abuse a body of men for the indiscretion of a few practitioners who use alcohol without reason is absurd. I always thought it was the monthly nurse who advised the ladies to resort to gin for pain in the back. The cited cases of intemperance induced by Dr Reid's indiscretion are all women. I hope he now understands the sex better, the scales having fallen from his eyes. Dr Reid thinks he has said enough to prove that we are guilty of causing intemperance. He certainly has not; but he has proved himself guilty of the indiscreet use of alcohol ten years ago. It is my pleasure to know that I have transformed the tippler into the total abstainer, and have never caused drunkenness. Let us still continue to discourage intemperance, and encourage coffee taverns and coffee billiard rooms; and hoping the time will soon arrive when tea and coffee can be had at our railway stations, cheaper than beer, or at least as cheap, and at a drinkable temperature.—I am, sir, yours truly, SHAPLAND WHITE, MD. (*British Medical Journal*, 1881.)